STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING _____ B. WING _____	R-C 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a Post Survey Revisit to the Investigation of Complaint IN00090322.

Complaint IN00090322-Corrected

This visit was in conjunction with the Investigation of Complaint IN00092667.

This visit was in conjunction with the Post Survey Revisit (PSR) to the PSR (6/2/11) to the Recertification and State Licensure Survey Completed on April 18. 2011.

Survey date: July 20, 2011

Facility number: 0000369
Provider number: 155530
AIM number: 100275190

Survey team:
Janet Adams, RN, TC
Lara Richards, RN
Kathleen Vargas, RN

Census bed type:
SNF/NF: 77
Total: 77

Census payor type:
Medicare: 3
Medicaid: 71
Other: 3
Total: 77

Sample: 9

South Shore Health & Rehabilitation was found to

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING _____ B. WING _____	R-C 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to Investigation of Complaint IN00090322. Quality review completed on July 21, 2011 by Bev Faulkner,RN	{F 000}		